STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6008734	A. BUILDING: _____ B. WING _____	C 09/08/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RAINBOW BEACH CARE CENTER	7325 SOUTH EXCHANGE CHICAGO, IL 60649

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S9999	Final Observations Statement of Licensure Violations Section 300.4030 Individualized Treatment Plan for Residents with Serious Mental Illness Residing in Facilities Subject to Subpart S c) The plan for each resident shall state specific goals that are developed by the IDT. The resident's major needs shall be prioritized, and approaches or programs shall be developed with specific goals, to address the higher prioritized needs. If a lower priority need is not being addressed through a specific goal or program, a statement shall be made as to why it is not being addressed or how the need will be otherwise addressed. d) The ITP shall contain objectives to reach each of the individual's goals in the plan. Each objective shall: 1) Be developed by the IDT; 2) Be based on the results obtained from the assessment process; 3) Be stated in measurable terms and identify specific performance measures to assess; and 4) Be developed with a projected completion or review date (month, day, year). e) Services designed to implement the objectives in the resident's ITP shall specify: 1) Specific approaches or steps to meet the objective; 2) Planned skills training, skill generalization technique, incentive/behavior therapy, or other interventions to accomplish the objectives, including the frequency (number of times per week, per day, etc.), quantity (in number of minutes, hours, etc.) and duration (period of time, i.e., over the next 6 months) and the support necessary for the resident to participate;	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1 3) The evaluation criteria and time periods to be used in monitoring the expected results of the intervention; and 4) Identification of the staff responsible for implementing each specific intervention. f) Whenever possible, residents shall be offered some choice among rehabilitation interventions that will address specific ITP objectives using techniques suited to individual needs. g) ITP Documentation: 2) The resident's response to the ITP and progress toward goals shall be documented in progress notes. k) The resident's treating psychiatrist shall review and approve the resident's treatment plan as developed by the IDT. The date of this review and approval shall be entered on the resident's treatment plan and be signed by the attending psychiatrist. n) Residents' attendance in therapeutic programs shall be recorded. These requirements are not met as evidenced by: Based on observation, interview and record review, the facility failed to develop an individualized treatment plan for admission to it's crisis stabilization unit for three of seven residents (R8, R16, R17) reviewed for specialized rehab services in a sample 18. Findings include: 1. On 8/27/15 at approximately 3:30pm, R8 was observed ambulating on the general unit. R8 stated that she has been caught violating the smoking rules a number of times, was "arrested" by staff and placed in "triage" for 21 days and staff do not do anything for her. R8 ' s Individualized Treatment Plan (ITP) dated 7/11/12 states R8 has a history of aggression and	S9999		

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assessment reveals verbal aggression and mood swings towards peers and staff. R8 was referred to Anger management on 6/2/13. The Plan does not specify frequency of attendance nor expected measurable goals. Review of R8's social service progress notes for period of 2/15/15 through 9/1/15 shows R8 participated in 5 anger management sessions over that time period, 2 of which were 1:1 counseling. There is no documentation to show R8' s response to this intervention.

ITP dated 8/6/14 states R8 will be assessed for Shoreline unit which provides resident with additional supervision and education. R8 has had 6 admissions to the Shoreline unit in the past 11 months. R8 was last discharged from Shoreline on 8/13/15 and continues to exhibit behaviors of agitation and physical aggression. There is no documented evidence to show individualized, measurable treatment goals and objective for admission to the Unit for R8. There is no evidence to show R8 ' s physician participation in the decision to admit R8 to Shoreline.

2. R16 was observed on the shoreline unit on 8/27/15, walking in the hallway and going in and out of her room. R16 stated this is her second transfer to this unit since admission to the facility on 6/9/15. R16 stated she was admitted to shoreline for aggressive behavior and did not know she could be " charged with a crime" of aggression which is a symptom of her illness. R16 described her experience in Shoreline as a "jail", the only difference is that in shoreline she is able to smoke. R16 stated she did not have a choice in the decision to be transferred to shoreline and that the residents in shoreline have nothing to do and receive no group therapy. R16's ITP dated 6/11/15 reveals R16 is at

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moderate risk for aggressive behavior. There are no specific psych-social rehabilitative treatment plan to address R16's aggression. On 6/30/15 and 8/18/15 R16 was assessed for Shoreline admission however, there is no plan of treatment for R16 while on that unit. Progress notes dated 8/10/15 states R16 was aggressive towards peer and staff and was reportedly calm after the incidents. R16 was admitted to Shoreline approximately 9 hours later for this incident. There is no evidence to show R16's physician being agreement with this admission.

R16's clinical record includes a signed agreement dated 6/9/15 (R16's admission date) for admission to the Shoreline unit for short-term treatment. E13 (Unit manager) stated on 9/2/15 at approximately 9:45am, that admission to the unit is a part of residents treatment plan upon admission as evidenced by all residents signing admission consent when admitted to the facility.

3. R17 was observed on the Shoreline unit on 8/27/15 at approximately 10:35am. R17 was in his room, very agitated, stating staff accused him of sexually harassing a staff member. According to R17, he has to be "locked up" for 21 days and "they don't do anything for me here".

R17 was admitted to the facility on 7/11/15. Interim treatment plan shows R17 has a history of incarceration, aggression and substance abuse. R17 signed a consent for short-term treatment on shoreline. ITP dated 7/15/15 states R17 will be referred to anger management 2 times each week for his history of aggression. The facility provided no evidence that R17 was receiving this therapy. According to facility staff, the anger management group is an open group and attendance is not documented. Progress notes

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S9999	Continued From page 4 dated 7/30/15 shows R17 admitted to the unit for increased aggression and inappropriate behaviors and remained on the unit for 19 days. R17 exhibited no aggressive behavior during his stay on the unit and was discharged on 8/18/15. There is no treatment plan for R17 ' s stay on the unit. There is no evidence to show R17's admission being approved by the physician. On 8/27/15 R17 was noted by staff with inappropriate behavior toward peer. There is no evidence to show R17 being counseled for this incident and 10 hours later, R17 was re-admitted to the shoreline unit. There is no evidence to show R17 ' s physician approving this re-admission. Treatment plan for R17's stay on the unit dated 8/27/15 is monitoring of R17's behavior and offer supportive counseling as needed. The plan does not outline type of counseling to be provided nor included measurable goals to prepare R17 for discharge off the unit.. E10 (Shoreline Unit Manager) stated on 8/28/15 at approximately 9:10am that the plan of care for residents admitted to the unit is to get them behaviorally stable and compliant with medication and mandatory counseling. The length of stay on the Unit is generally 21 days and at times they come off the Unit earlier if there is another resident more needy of the service or if another resident is admitted on the Unit that may pose as a threat to a specific resident currently on the Unit. E10 went on to say that decision to admit a resident to the Unit is made jointly by E1 (Administrator), E2, E3 (Director of Nursing) and the nurse manager on the unit. E10 did not identify the physician as a pert of the decision process. According to E10, this interdisciplinary	S9999 0		

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team (IDT) notifies the residents ' physician who signs off on the decision to admit. Residents ' progress notes indicates residents are admitted prior to physician ' s notification. E10 further stated he is not sure if the physician always signs admission agreement. According to E10, the main focus of treatment on the Shoreline Unit is medication management and an ITP is developed for residents' stay on the Unit.

There is no documented evidence to show individualized, measurable treatment goals and objective for treatment to the Unit. There are no written criteria for residents ' discharge from the Unit

E2 (Assistant Administrator - Psychosocial Rehabilitative Service Director - PRSD) stated on 9/3/15 at approximately 3:30pm that the Anger Management group is an open group and attendance is not mandatory nor is attendance recorded.

E5 (Program Manager) stated on 9/4/15 at approximately 11:35am, that the facility follows a specific module for its Anger Management group and presented a module designed to train staff on how to use the module. Additionally for Symptom Management, E5 presented a learner ' s module.

E4 (Nurse - Shoreline Unit) stated on 9/4/15 that she is responsible to make sure residents medication is transferred from the general unit. According to E4, residents time on the unit is spent mostly in supervised social activities. According to E4, there are no group sessions conducted on the Unit and residents occasionally meet with the unit manager for 1:1 counseling.

E13 (Unit Manager - Shoreline Unit) stated on

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9/2/15 at approximately 9:45am that Shoreline is a crisis stabilization unit where residents receive skilled training and therapeutic interventions. Residents' length of stay is a maximum of 21 days and the decision to admit residents on the unit is made by the IDT. E13 identifies nursing, social service, medical and psychiatric physicians as members of this team. E13 stated that a resident's admission to shoreline is part of their treatment plan. According to E13, once a resident's behavior is observed to be stable, there are no set timeline for discharged off the unit. E13 stated that upon admission she educate residents on the facility's behavior policy and expectations for compliance. E13 said she believes she clearly state to the residents what they need to work on in shoreline to warrant discharge. According to E13, there are no written ITP for residents' stay on shoreline. E13 also stated there are no documented group attendance on shoreline and this information is summarized in the residents' progress notes.

(AW)
300.1620b)e)
300.3220 f)

Section 300.1620 Compliance with Licensed Prescriber's Orders
b) Telephone orders may be taken by a registered nurse, licensed practical nurse or licensed pharmacist. All such orders shall be immediately written on the resident's clinical record or a telephone order form and signed by the nurse or pharmacist taking the order. These orders shall be countersigned by the licensed prescriber within 10 calendar days.
e) The resident's licensed prescriber shall be notified of medications about to be stopped so

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that the licensed prescriber may promptly renew such orders to avoid interruption of the resident's therapeutic regimen.

Section 300.3220 Medical and Personal Care Program

f) All medical treatment and procedures shall be administered as ordered by a physician. All new physician orders shall be reviewed by the facility's Director of nursing or charge nurse designee within 24 hours after such orders have been issued to assure facility compliance with such orders. (Section 2-104(b) of the Act)

These requirements are not met as evidenced by:

Based on interview and record review the facility failed to order and administer antipsychotic medication upon readmission for one resident (R3) of four residents reviewed for medications in the sample of 13 residents.

Findings include:

Resident Progress Note dated 8/21/15 at 8:34pm indicates that R3 was hospitalized on 8/18/15 with complaints of auditory hallucinations with voices telling him to kill himself and readmitted to the facility on 8/21/15.

Hospital Discharge Summary/Medication Reconciliation date 8/21/15 indicates that Quetiapine/Seroquel (antipsychotic) 400 mg (milligrams) to be administered daily at bedtime for Schizo-affective was ordered for R3 on 8/21/15 at 3:17pm.

Medication Administration Record (MAR) dated 8/1/15 to 8/31/15 indicates that Seroquel 400mg

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S9999	Continued From page 8 Daily was not administered on readmission of 8/21/15 and that Seroquel 400mg every 12 hours was initiated after R3 was aggressive toward a peer and sent to the hospital for evaluation on 8/24/15. MAR indicates R3 was administered Seroquel 400mg on 8/25/15 at 8:30pm. Physician Order Sheet dated 8/1/15 to 8/31/15 indicates that Seroquel 400mg every 12 hours was discontinued on 8/21/15. R3 did not receive Seroquel from 8/21/15 to 8/25/15 as ordered on readmission orders of 8/21/15. On 9/4/15 at 1:35pm E3, Director of Nursing (DON) stated "Normally I review admissions and readmission orders but I was sick that day (8/21/15)." E2 further stated that there is no one to do the reviews when she is not here and she was unable to review R3's admission when she returned back to work. On 8/28/15 at 10:50am Z2, Psychiatrist stated that he was not aware R3 was not receiving the Seroquel ordered on readmission. Z2 stated that he told staff to continue all medications on the hospital discharge instructions. Z2 stated "It sounds like a transcription error." When asked if three days without his antipsychotic medication could have contributed to R3's instability and aggression toward his roommate on 8/24/15, Z2 responded "He should have been on the medication as ordered." Facility Policy Medication Administration dated 11/03/14 indicates: Medications are administered in accordance with written orders of the prescriber. (B)	S9999		

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